March 2010

Dear Parent(s)/ Guardian(s) of a Prospective Ramah Outdoor Adventure Camper:

You are considering a unique and formative Jewish adventure camp for your child. Ramah Outdoor Adventure (ROA) differs from other Ramah camps in that campers will go on strenuous multi-day trips outside of camp, high up in the Rocky Mountains, at a fair distance from an urban center with comprehensive medical facilities.

This new Ramah camp will present your child with outdoor challenges and Jewish learning. As members of the medical committee, we also want to make you aware of the following facts as you consider this camp:

- Campers will be away from base camp and trained medical staff for up to five days during excursions. Children who need frequent medical oversight or who have chronic illnesses (including but not limited to diabetes, seizure disorders, and severe asthma) needing close monitoring will not have access to appropriate care.

- ROA is not appropriate for campers with chronic medical illnesses needing significant care and ROA will not accept these campers.

- Because campers will be traveling on remote trails far from the camp infirmary for up to five days during excursions, ROA will not accept campers who need medication administered more than two times per day, nor anyone who requires refrigerated medicine.

- Children with severe allergies – particularly allergic reactions that could lead to anaphylactic shock – will not have appropriate access to care and will not be accepted. Specifically, campers with bee sting allergies and other severe environmental allergies *cannot* be accepted. ROA will be nut-aware, striving to have no peanuts, tree nuts, or peanut butter on site, but cannot guarantee against cross-contamination or the presence of food produced on machines with nut products. If your child has **anaphylactic reactions to food contaminants or peanut dust, they will not be accepted, as the absence of these allergens cannot be guaranteed.**

- For campers needing regular medications, we have contracted with CampMeds (www.campmeds.com) to provides prepackaged and dated doses of prescribed medication. A written prescription from your child's physician(s) needs to be provided to CampMeds, who will bill your insurance company directly. You will be responsible for any co-pay. The only allowable exception to using CampMeds will be if CampMeds does not contract with your insurance provider.

- The Ramah Outdoor Adventure base camp is situated approximately 1½ hours away from a hospital. If an emergency occurs, it may be necessary to have a camper airlifted by helicopter for acute issues. A helicopter takes 20-30 minutes to arrive on site. An ambulance takes 45-60 minutes to arrive at the site via the road.

- All camper medical histories will be screened by the medical committee prior to final camp acceptance, in order to make ROA a safe experience for each camper.

  In summary, Ramah Outdoor Adventure will not accept any campers who:
  - **Have a chronic medical condition requiring ongoing medical care**
  - **Require medication more than twice daily**
  - **Require refrigerated medicine**
  - **Have the possibility of anaphylactic reaction to food allergens**
  - **Are allergic to bee stings or have other severe environmental allergies.**

We are aware that H1N1 influenza was an issue at many residential camps last summer. We want to protect your child and all campers and staff, and promote a healthy camp. Therefore, we will ask you to monitor your child prior to arrival and will screen each child with a verbal questionnaire, temperature check, and screening for influenza- or H1N1-like symptoms prior to transport to camp, and again at camp. We strongly recommend immunization against H1N1 and influenza, in consultation with your child's physician.

We welcome your child's participation in this camp. Please be aware that the medical forms attached must completed and returned by your child's physician before May 1, 2010 so that the medical committee can review them.

Sincerely,

The Ramah Outdoor Adventure Medical Committee

Marc Avner, MD
Tashof Burnton, MD
Goldie Cohen, MD
Benjamin Honigman, MD
Noah Makovsky, MD
Laurie Morris, RN
Jennifer Wolf, MD

2010 - MEDICAL FORM

PLEASE CHECK ONE:

☐ **CAMPER** ☐ **STAFF**

PART I:

Name ***(please print)*** _____ Sex: ☐M ☐F
Date of Birth _____/_____/_____ Social Security Number _____ - _____ - _____
Address _____City _____State ____ Zip _____
Name of Parent/Guardian I _____
Name of Parent/ Guardian II _____
Home ph :(_____) _____ Work ph: (_____) _____ Cell ph: (_____) _____
Home ph :(_____) _____ Work ph: (_____) _____ Cell ph: (_____) _____
If parents are not available in an emergency, please notify:
Name_____ Home ph: (____) _____ Cell ph: (____) _____
Name_____ Home ph: (____) _____ Cell ph: (____) _____

****It is mandatory you attach a legible copy of the front and back of your insurance card to this form.**

►**Medications brought to camp**

Dosage	**Frequency**	**Time of Day**	**Indication**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

►List allergies and describe allergic reaction (*wheezing, hives, etc.*)

	Allergy	Type of Reaction	Treatment
Penicillin	_____	_____	_____
Other Drugs	_____	_____	_____
Bee Stings	_____	_____	_____
Other Insect Stings	_____	_____	_____
Food (please specify)	_____	_____	_____
Plants and Pollen	_ _____	_____	_____
Other	_____	_____	_____

►Does your child have any **special dietary needs**? ☐Yes ☐No
If so, please specify if child is vegetarian, is lactose intolerant, gluten free, etc._____
_____
►Date of last Tetanus booster_____

●*I certify that all information in this medical form is true and accurate and there has been no omission of data. Noncompliance may result in expulsion without a refund.*
● HIPAA authorization: *By signing below, I acknowledge reading the Notice of Privacy Practices followed by Camp Ramah Outdoor Adventure*
●*I authorize Camp Ramah medical personnel to administer the prescribed medications brought from home.*
●*In case of medical and/or surgical emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment and to order injections, anesthesia, X-rays, surgery or any other appropriate measure for the person as named above.*
●*I understand that in such an emergency, it is camp policy to make every effort to reach the parent of a camper in advance of treatment.*

_____**OR** _____
Signature of Parent(s)/Guardian(s) of Camper *Signature of Staff member over age 18*
Note: separated/ divorced parents with joint custody are each required to sign this form

Name: _____

IMPORTANT: Please notify the camp director at 303.261.8214 if you have been exposed to any reportable communicable disease during the three weeks prior to arriving to camp.

PAST MEDICAL HISTORY

Please provide complete, accurate and up-to-date information, so that we can provide you with a continuation of the consistent care you receive at home.

Primary Care Provider's Name:_____Phone#:(___)_____
Dentist's Name:_____Phone #:(___)_____
Orthodontist's Name: _____Phone #:(___)_____
Ophthalmologist's Name: _____Phone #:(___)_____
Psychologist/Psychiatrist/Therapist's Name: _____Phone #:(___)_____
Allergist's Name:_____Phone #(___)_____

If necessary: Do we have permission to contact your medical care providers? ____ Yes ____ No

HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING:

	NO	YES
ASTHMA		o Mild o Moderate o Severe o Chronic Medications o Past Hospitalization o Additional Information_____
DIABETES		o Insulin Dependent o Diet Controlled o Oral Medications o Restrictions_____
HEART DISEASE		o Type _____ o Restrictions_____
HYPERTENSION		o Chronic Medications _____ o Restrictions_____
SEIZURES		o Type _____ o Chronic Medications_____ o Restrictions_____
ADD/ADHD		o Age of Diagnosis _____ o Current treatment _____
EATING DISORDER		o Age of Onset _____ o Type_____
STOMACH INTESTINAL DISORDERS		o Type_____ o Current treatment _____
PRIOR SURGERY		o Type_____ Date_____ o Restrictions_____
OTHER:		Describe: _____ _____
ANY EMOTIONAL OR BEHAVIORAL DIFFICULTIES		Describe Type & Reaction:

If "**yes**" to any of the above, please explain in greater detail: _____

►If you checked ADD/ADHD, depression, OCD, or other psychological conditions, please describe the condition_____

_____

Has medication been prescribed? □Yes □No Name of medication_____
Prescribing physician_____ Phone # (_____) _____
Dosage/frequency/time of day_____

►Have you had any major illnesses, operations, or significant injury (concussion/fracture) in the past, which might, even remotely, bear on your health needs at camp? □Yes □No

Describe_____

►Have you been hospitalized or have you received outpatient treatment in the past year? □Yes □No
If yes, please explain_____

►If you wear glasses, please label the case with your name, and remember to pack an extra pair!

STAFF OVER AGE 18

►**Measles Date: _____**
►**Mumps Date: _____**
►**Rubella Date: _____**
If you were born in 1957 or later, two (2) doses of MMR vaccine are required, OR proof of laboratory evidence of immunity.
Date of MMR Dose #1 _____
Date of MMR Dose #2 _____
Or attach proof of immunity here

►**DTtaP/DPT/DT/Td List Dates:**
(1) _____ (2) _____ (3) _____
A booster dose of Td is required if more than 10 years has elapsed since last dose. Date: _____

►**TB Skin Test Date: _____**
Result: □ Positive □ Negative
If positive, date of most recent chest x-ray: _____

► **Hepatitis B:** *College: All Health Science; Freshman-Graduate.*
Three (3) doses of Hepatitis vaccine are required.

- **H1N1 Date_____**

CAMPERS AND STAFF UNDER AGE 18

►**MMR Vaccine**
First dose (at or after 12 months of age) Date: _____
►**MMR Vaccine**
Second dose (administer 2nd dose of MMR at age 4-6 years) Date: _____

► **Polio Vaccine (OPV or e-IPV)**
Dates: (1) _____ (2) _____ (3) _____ (4) _____

►**DTaP/DPT/DT/Td *Dates*:**
(1) _____ (2) _____ (3) _____ (4) _____
If child is age 13 or older at the time of first dose, another dose is required **(5) _____**

► **Tetanus Booster** *Date*: _____
(If more than 10 years has elapsed since the last dose)
A booster dose of Td is required for all students entering grades 7-12 if it has been more than 5 years since their last dose of DTaP/DPT/DT/Td

► **Hepatitis B**
Three (3) doses of Hepatitis vaccine are required for all children born on or after 1/1/92 *Dates:* **(1) _____ (2) _____ (3) _____**

► **Varicella Vaccine (Chicken Pox)**
Vaccine Date: _____ OR Date of Chicken Pox: _____
Administer 2nd dose of vaccine at age 4-6 years OR – MD documentation that camper has had chicken pox

- . **H1N1 Date_____**

Name: _____

PART II: To be filled in completely by M.D. or D.O. *Physician: Please review Part I for completeness.

IMMUNIZATIONS:

DEAR PHYSICIAN:

You have been asked to perform a medical screening and evaluation form for a prospective camper at Ramah Outdoor Adventure for the summer 2010 sessions. This camp differs from other Ramah camps in that campers will go on five-day trips outside of camp. These trips will occur at altitude, in the remote backcountry of the Rocky Mountains, and will be a fair distance from an urban center.

This new Ramah camp will present the camper with outdoor challenges and Jewish learning. As members of the medical committee, we also want to make you aware of the following facts as you evaluate your patient for inclusion:

- As above, campers will be away from camp and from direct medical care on multi-day trips. Children who need frequent medical oversight or who have chronic illnesses that need close monitoring will not have access to that care while away from base camp.
- Because of the multiple days away and trail/camping aspect, we will not accept campers who need medication administered more than two times per day.
- This Ramah camp is situated approximately 1½ hours away from a hospital. If an emergency occurs, it will be necessary to have a camper airlifted by helicopter for acute issues. An ambulance takes 45-60 minutes to arrive at the base camp site by

the road. Ambulance response to back country trailheads may be longer. If you anticipate that this camper will need frequent medical care for ***any reason***, please note it on the form. This camp may not be a good option for that camper.

- Children with severe allergies – particularly allergic reactions leading to anaphylactic shock , or a history of swelling in reaction to an allergen, including foods, beestings, and the like – will not have appropriate access to care and will not be accepted. The policy on nuts will be that no actual nuts will be at camp, but products containing nuts will be served in single-serving containers. We cannot guarantee that cross-contamination will not occur, but we will try to prevent it.
- We are aware that H1N1 influenza was an issue at many residential camps last summer. Please note if this child had an H1N1 vaccination for this year. We will ask parents to monitor campers prior to arrival and will screen each child with both a verbal questionnaire and a temperature check prior to transport to camp. This policy is in place to protect all campers and staff, and to promote a healthy camp.

A. HISTORY

Physician: Please describe any additional health conditions, especially chronic, recurring or potential problems not noted in PART I, or any other information that Camp Ramah and medical staff need to know about this camper.

_____

_____

B. **IMMUNIZATIONS** (above) – please fill out COMPLETELY including H1N1 vaccination.

C. PHYSICAL EXAM *Date of exam used for this form must be after 6-1-2009* Date: _____
Height _____ Weight_____ Blood Pressure _____ Pulse _____
☐ Entirely Normal ☐ Normal except for _____

D. LAB *(if appropriate):* Hct _____% or Hgb ____gms Urine: ☐ Normal ☐ Abnormal Date: _____

E. RECOMMENDATIONS AND/OR RESTRICTIONS for health maintenance during the summer.

Regularly Taken Medications	*Dosage*	*Indication*	*Directions*
_____	_____	_____	_____
_____	_____	_____	_____

P.R.N. Medications	*Dosage*	*Indication*	*Directions*
_____	_____	_____	_____
_____	_____	_____	_____

Activity Restrictions: ☐ None ☐ As follows: _____
Medical Dietary Restrictions: ☐ None ☐ As follows: _____

RECENT acute medical or surgical problems that may require observation or follow-up at camp: _____ _____

*I have personally reviewed the attached medical history and examined the above named individual. S/He was examined and found to be in satisfactory health and apparently free from communicable disease. There are no apparent contraindications to participating in routine Camp activities.

_____

Signature of Primary Care Provider (MAY NOT BE THE PARENT) | License Number | Date

_____

Primary Care Provider (PLEASE PRINT) | Phone Number

_____

Street Address | City | State | Zip Code

Name: _____

PART III. **CAMP PROGRESS NOTES** *(to be filled out at camp)*

Date **Weight** Medical Staff Review_____ *initials*

Check in_____ Check out_____

DATE	COMPLAINT	DIAGNOSTIC/TREATMENT & PHYSICAL FINDINGS	ADVICE	SIGNATURE RN/MD

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND KEEP FOR YOUR RECORDS. YOU DO NOT NEED TO RETURN THIS FORM TO CAMP RAMAH.
The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individual identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your heath information is used.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be any treatment required beyond the camp Infirmary.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may need to give your insurance company information about your treatment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, cost-management analysis and accreditation.

We may also use and disclose health information:
- To designated members of Camp Ramah staff directly involved in your care, e.g. counselors, trip leaders, affiliated staff.
- To remind you that you have an appointment for medical care.
- To family members and close friends involved in your care. There may be some situations in which parental access to their minor's PHI may be denied or restricted, provided the decision is made by a licensed health care professional in the exercise of professional judgment.

We may be required to disclose your protected health information (PHI), without your consent or authorization, if required by law, including but not limited to:

- Food and Drug Administration
- Public Health Authorities
- Workers Compensation Agents
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Law Enforcement Officials

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request.

Under the law you have specific rights – subject to certain exceptions and limitations:

- The right to request restrictions on certain uses and disclosures of your PHI, including those related to disclosures to family members, other relatives, close friends, or any other person identified by you. All requests for such restrictions must be made in writing. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to inspect and copy your PHI under supervision of Camp Ramah Infirmary staff.
- The right to amend your PHI. All requests for amendments must be in writing.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to receive confidential communications.
- The right to revoke your authorization.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We may change the terms of this written notice and make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. The new notice will be posted in the Infirmary and will be available in the camp office.

If you believe your privacy rights have been violated you may complain to us and to the Secretary of the United States Department of Health and Human Services. You may file a written complaint with the Infirmary Supervisor. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint: The US Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
(202) 619-0257 www.hhs.gov/ocr/hipaa

_____

Parent(s) /Guardian(s) signature(s) or staff, if over 18 years old
Please note: separated/divorced parents with joint custody are each required to sign this consent form

Medical Forms Fact Sheet- 2010

 State law and the American Camp Association require us to have a current medical form on file for each camper. Please complete and return the enclosed 2010 medical form **by May 1, 2010.**

 It is essential that this form be filled out completely in order for us to provide your child with a continuation of the care they receive at home. Please list all the medications your child is taking, and any special conditions your child may have so we can best provide for your child's physical and mental health.

 Please read both the Notice of Privacy Practices and the HIPAA release information and **include your signature at the bottom of the page.**

 We are using **Camp Meds** as our provider for your child's regular medication needs. Please read the Camp Meds description on the reverse side of this page and the registration information enclosed. Follow the instructions to sign up for the program as needed.

 Camp Meds charges each family an administration fee up front for their services. Copay payments for the actual medications dispensed are charged to the credit card you provide to Camp Meds at the end of each session.

 We want to be clear that we expect **100% participation** from families with campers who will need medication while at camp. Families whose medical needs can't be filled through **Camp Meds** must obtain a release from ROA or a $100 administrative fee will be charged to your camp account. The only exception to this procedure is if **Camp Meds** notifies us that they are unable to accept your insurance. If your camper does not take medication in pill form, you do not need to register with **Camp Meds**.

 Camp Ramah requires a copy of the front and back of your insurance card in order for us to fill any non-foreseeable prescription needs that may arise during the summer.

 Please feel free to contact the camp director, Rabbi Eliav Bock, at eliavb@ramahoutdoors.org or 303.261.8214 with any questions.